STATE OF VERMONT
DEPARTMENT OF LABOR & INDUSTRY
WORKERS COMPENSATION DIVISION
NATIONAL LIFE DRIVE, DRAWER 20
MONTPELIER, VT 05620-3401
(802) 828-2286

www.labor.vermont.gov

**Form 25M** **Rev 3/07**

**State File No.:** _____

**Insurance Co. File No.:** _____

**Date of Injury:** _____

This form shall be filed whenever a claimant is eligible to receive more than 90 calendar days of continuous temporary total disability benefits (see Rule 53.1100). Failure to file this form promptly and accurately may result in administrative sanctions pursuant to Rule 45.000.

# MEMORANDUM OF PAYMENT

## Employee

Last Name: _____ First Name: _____

Mailing Address _____ City _____ State _____ Zip _____

Telephone Number _____

## Employer

Employer Name _____

Insurer _____

## Payment Made

Weekly Compensation

Date Disability Payment Began: _____ Amount Paid: _____

Total Amount Paid To Date: _____

Other: (Please Explain)

_____

**ISSUED BY:**

Carrier: _____ Administrator (if not carrier): _____

Adjuster Name: _____ Telephone No. _____

Adjuster Signature: Employer: _____

Adjuster License #: _____